DOCUMENT RESUME

ED 306 490 CG 021 623

AUTHOR Nagy, Thomas F.
TITLE Boundaries of Competence: Training and Therapist Impairment.
PUB DATE Feb 89
NOTE 12p.; Paper presented at the Annual Meeting of the California State Psychological Association (San Francisco, CA, February 25-28, 1989).
PUB TYPE Reports - General (140) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Competence; *Counselor Training; *Failure; Job Performance; *Psychologists; Skills

ABSTRACT

Psychologists, by the very nature of their work, are faced with practicing at the borders of their competence, for two reasons. First, they may encounter certain clients or situations for which they are only minimally prepared; and second, as human beings they are subject to the same destructive effects of untoward life events as their clients, despite a tendency to consider themselves immune. There are at least three ways of practicing outside one's areas of competence: (1) accidental--practice beyond one's competence; (2) deliberate practice beyond one's competence; and (3) failure to use community resources. Therapist impairment can be defined as compromised judgment, competence, or ability to carry out professional activities as they directly or indirectly affect others. Frequently, the cause of such impairment is a series of significant life events, as viewed by an objective observer, though the psychologist may not always be aware of the toll which has been taken. To avoid the pitfalls of practicing beyond one's area of competence, therapists should improve their diagnostic and treatment skills; refuse to accept certain clients for whom they are not well prepared to treat; know personal danger schedules and monitor one's own mental health; consult a senior colleague when in doubt; limit one's practice as necessary; belong to an ongoing professional peer group; and be current and familiar with the state-of-the art. The return on the investments of time and money in these areas is immense, including expanded professionalism, reduced risk of ethics complaints, and a higher quality of service. (ABL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED306490

BOUNDARIES OF COMPETENCE: TRAINING AND THERAPIST IMPAIRMENT

Thomas F. Nagy, Ph.D.
Department of Psychiatry
Stanford University School of Medicine

CG 021623

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Thomas F Nagy

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Presented at the California State Psychological Association Annual Convention, Feb. 25-28, 1989, in San Francisco

INTRODUCTION

One of the most ethically difficult and heart-wrenching cases with which an ethics committee has to contend is the well-intentioned therapist who practices beyond his or her limits or is unknowingly suffering an impairment of some sort. There, but for the grace of God, might go any one of us in this room, at one time or another in our lives. As psychologists, by the very nature of our work, we occasionally are faced with practicing at the borders of our competence, for two reasons: 1) Certain clients or situations for which we might be minimally prepared (or totally unprepared) may present us with greater challenge, complexity, or even excitement, inducing us to overextend, and, 2) as human beings we are subject to the same destructive effects of untoward life events as our clients--this,in spite of a tendency to possibly think of ourselves as immune.

In this paper I will be focusing on the ethical issues concerning Principles 1 (Responsibility) and 2 (Competence), although, this topic cuts across virtually <u>every</u> principle, with particular relevance to Principle 6, (Welfare of the Consumer). By way of providing some transparent examples I would like to present the following two vignettes, and then discuss practicing beyond one's training and while impaired. I will conclude by giving nine guidelines for avoiding both pitfalls.

<u>Vignette #1:</u>

1) A man and his wife of 20 years present with sexual dysfunction; he suffers from erectile dysfunction and she complains of dyspareunia. In addition, the man has some depressive symptomology, leading towards an Axis I diagnosis of Adjustment

Disorder with Depression. The psychologist, who has had a one-day workshop in sex therapy, judges the depression to be secondary to inadequate sexual functioning, and begins sex therapy with the couple. After six sessions the husband is more depressed and is drinking heavily; he has failed at all the assigned behavioral homework exercises, feels humiliated, worthless, and hopeless, and makes a suicide attempt.

Vignette #2:

2) A psychologist has just suffered the loss of his wife of 12 years in a traffic accident. As a means of denying this massive loss he now immerses himself in the work of seeing as many patients as he possibly can in therapy and performing numerous psychological assessments. Within a few weeks he notices that he is feeling drawn to a particular female patient; he finds her especially sympathetic and strangely familiar at times, and strongly seductive and exciting at other times. He has diagnosed her, in the back of his mind, as a probable Borderline Personality Disorder, but is able to keep that diagnosis safely out of his consciousness. Within a short time he begins a social relationship with her, meeting for lunch. Soon thereafter their relationship deteriorates into a sexual one, with much concomitant destructiveness and complications unfolding in the months ahead.

Fortunately, not every instance of practicing while impaired or outside one's competence results in such destructiveness. And, certainly, some of the time, the psychologist may remain essentially unaware of the impact of his or her mispractice with clients, as they may simply drop out of treatment. However, there are some themes concerning therapist training and impairment which do recur sufficiently often for us to generalize about them. I would like to address these

first by discussing the different ways in which psychologists are apt to practice outside their areas of training.

VARIETIES OF PRACTICING OUTSIDE ONE'S AREAS OF TRAINING

There are at least three ways of practicing outside your areas of competence which I would like to address, and they each involve, in some way, the concept of "not knowing what it is you don't know." The three categories are 1) "Accidental" practice beyond one's competence (blind spots or ignorance), 2) Deliberate practice beyond one's competence ("super-therapist fantasies"--thinks s/he can treat anyone and everyone), and 3) a special category resulting from the first two--failure to use community resources.

I would like to address the first category--accidental practice beyond one's competence--which I define as unknowingly possessing inadequate knowledge and skills in certain areas while continuing to render psychological services in these areas (e.g.--diagnosis, treatment, testing, etc.). Poor diagnostic skills on Axis I, for example, might result in a failure to adequately assess the suicidal potential of a patient. Incompetence on Axis II might result in a lengthy delay in reaching a diagnostic impression, or even failing to do so altogether; in the latter case this may result in treatment which is significantly substandard, with greater ensuing risks for the patient who suffers from a character disorder.

In examining our 1st vignette, the depressive/dysfunctional couple, it is probably apparent to most of us that the depression should have been treated before sex therapy was ever initiated. The therapist who was minimally trained accurately diagnosed depressive symptoms but failed to see the importance of treating it prior to undertaking sex therapy. As a result, the consumer suffered an

exacerbation of symptoms. This is a typical scenerio, where the attendant risks to inadequate diagnosis may be inadequate treatment and the development of iatrogenic symptoms; the patient may get worse. Not only can this result in an exacerbation of the existing affective disorder or increased potential for acting out, but also may bring a crisis in confidence in the very process of therapy itself; the consumer may lose hope in his/her ability to improve. In this case, the psychologist may have "poisoned the well" for that patient as regards psychotherapy, for a limited period of time, or, conceivably, forever.

Virtually <u>any</u> psychological service can be compromised by unknown inadequate skills. In the area of assessment and testing, for example, the psychologist with "blind spots" might err by either misusing or <u>not</u> using a psychological instrument when it is indicated. Examples of misuse might include using an obsolete version of a test (instead of the current edition), using a test for which one had no education or training, using the <u>wrong</u> test for a particular purpose (using a WAIS instead of a WISC), or using test results for invalid purposes. The last example, using test results for invalid purposes, might involve overinterpreting test data or going beyond the capability of a test in formulating interpretations--such as attempting to assess parenting capability in the course of a child custody dispute by administering a Stanford-Binet, instead of using instruments which might provide better or more relevant measures of psychological strengths and weaknesses. Examples of other "blind-spots" which hamper the well-meaning practitioner are too numerous to mention here.

The second category of incompetent practice would be the <u>deliberate</u> rendering of psychological service outside of one's area of training. This would include those cases where one knowingly provides a psychological service for which there has been no formal education, training, or supervision, there is not likely to be,

and other qualified psychologists are accessible to the patient. Examples might be providing psychotherapy for a child when there has been no training in this area, or representing oneself as an expert in alcoholism treatment when one is, in fact, untrained in the specialty. Each of these might present considerable risks to the patient, and would likely be clear violations of Principle 2, which exhorts psychologists to "recognize the boundaries of their competence and the limitations of their techniques". In deliberately offering treatment, consultation, assessment, or any service for which there has been no training, the psychologist is not only behaving unethically but may be knowingly creating additional risks for the patient as well--he or she may get worse.

The third category of practicing beyond one's competence emerges from the previous two--namely, providing services to members of specialized populations, such as the elderly, or those individuals in minorities due to culture, sexual preference, or other reasons. cultural, sexual orientation, socio-economic status while remaining ignorant of important community resources. Typical examples would be the client whose ethnic identity differs greatly from the psychologist, the patient with Alzheimer's Disease, or the client who is gay or lesbian, is drug dependent, or is a battered wife. For these individuals there are frequently community support groups which may play a central role in treatment--e.g.--Gay/Lesbian counseling services and networking groups, Alzheimer support groups, Women's Shelters, and Alcoholics Anonymous, to name a few. It is sound ethical and clinical practice for a psychologist to utilize community resources when they have been proven to be efficacious. Failure to utilize them as adjuncts to or even in place of individual consultations would be a serious omission of the treatment plan for certain patients. In effect, the therapist may be functionally depriving patients of needed community resources by encouraging continuing professional

consultation in the absence of such referrals. Although not necessarily always unethical conduct this may be considered unprofessional at times or at least a diminished level of competence.

THERAPIST IMPAIRMENT

Therapist impairment could be defined as compromised judgement, competence, or ability to carry out professional activities as they directly or indirectly affect others. Frequently, the cause of such an impairment is a series of significant life events, as viewed by an objective observer, though the psychologist may not always be aware of the toll which has been taken.

Some of the more obviousevents which could adversely any of us are as follows: 1) a life crisis (e.g.--divorce, death of a family member or close friend, financial crisis), 2) moving to a new community or job, or, 3) a change in physical health (e.g.-an accident, or the sudden onset of an illness or acute pain). Examples of more subtle events might be 1) chronic low-level pain (e.g.--arthritic, muscle tension, etc.), 2) chronic low-level stress (e.g.--ongoing frustration about a marriage or family life, financial difficulties, etc., or 3) the gradual onset of a debilitating disease, where denial might enable one to function professionally in an impaired way rather than acknowledging the disability.

The psychologist in the second vignette who suffered the death of his wife was probably more impaired than he realized. After the death he immediately immersed himself in work, allowing no time or energy for processing his loss. Out of his own great need he began to respond to his patient's seductiveness. As time went on he lost his objectivity and ability to function as a therapist, yet, very likely, could not observe this occurring. The therapeutic relationship

deteriorated, and soon therapist and client were participating in behavior which, in the long run, would very likely be destructive to one or both.

HOW TO AVOID PRACTICING BEYOND YOUR LIMITS OF COMPETENCE

There are several simple guidelines for avoiding the pitfalls of practicing beyond one's area of competence; I'd like to briefly outline them.

1) Improve your diagnostic skills.

To be sure, it is difficult to know when you are in "over your head" with a new patient if you are uncertain about diagnosis. If diagnosis has not been a particular strength of yours, decide which means will be most useful in reliably differentially diagnosing on both Axis I and II-- objective testing, projective testing, a Structured Clinical Interview (SCID), or some other means. Read, take workshops/classes, seek consultation, develop your skills systematically in any way that you can.

2) Improve your treatment skills.

In providing services to the patient who presents a particular challenge, either by way of management (e.g.--eating disorders, suicidal), transference or countertransference (e.g.--Narcissistic or Borderline Personality Disorders), or in some other way--be aware of your vulnerable areas. If you think you could profit from additional education, training, and/or supervision--get it without delay.

3) Refuse to accept certain clients--"Just Say No".

Certain patients may present too much of a challenge. It is important to know when to say "no", even though the client-to-be thinks you may be their ideal choice or if you have come very highly recommended by a colleague. No one knows your limitations better than you do; if you have a good reason to doubt your capability with a certain client or lack experience--say so--and provide the individual with

another resource if you can. By such a cautious approach you avoid risking harm to consumers as well as saving them the time, money, and stress involved in changing therapists in mid-stream later on.

4) Know your own danger signals.

When you begin to feel or behave significantly different with a certain patient or at a certain stage of treatment you may be responding to your own needs rather than those of the patient. As your work progresses you may observe any of the following as potential danger signals: looking forward with fear or anticipation to each session, wishing to extend or shorten the sessions, scheduling a certain client consistently late in the evening, thinking/daydreaming about meeting the patient in an unprofessional setting, giving "special treatment" to the client by censoring yourself or in some way departing from your usual therapeutic style, having sexual fantasies about the patient, having other "non-professional" thoughts about the patient (asking advice, business tips, etc.), or dreaming about him/her.

5) Monitor your own mental health.

If you encounter a period of high stress, personal loss, financial difficulty, illness, or personal crisis, be aware that you could develop impaired judgement or skills. Be sensitive to your own changes in mood, sleeping and eating habits, activity level, or other manifestations of diminished mental health. As mental health providers we are not immune to the normal effects of overstress, but we may have a greater tendency to deny them.

6) When in doubt (even a little) consult a senior colleague.

Whether your doubt concerns competence, over-involvement, change in mental health, or any aspect of your professional or personal functioning, seek out an experienced colleague who is likely to view you with some objectivity. This may not necessarily be a close friend, and, in some cases, might even be someone who you do

not even know. If this is the time to have a professional consultation yourself, or to begin psychotherapy or marriage counseling select your therapist wisely. Do not choose a friend or fellow staff-member--the duality of the relationship would inevitably present problems for either or both of you.

7) Limit your practice as necessary.

If your life stress restricts some aspect of your professional practice you may need to exercise a greater selectivity in the patients you treat. For example, a therapist in the midst of an acrimonious divorce and child-custody battle may be ill-equipped to carry out marital counseling. He or she may find that even providing therapy to opposite-sex patients is too difficult, particularly with those who have conflicts with spouses. In this case difficult clients should be referred, and only those clients who can be competently treated should be accepted.

8) Belong to an ongoing professional peer-group.

These groups exist for the purpose of exploring such professional/clinical/ethical issues as may arise during the normal course of one's practice or discussing difficult cases. This might consist of regular meetings with half a dozen colleagues, who ultimately might become quite important in sharing their insights and professional judgments. Such a leaderless group can serve as a professional mainstay for some therapists with particularly taxing patients.

9) Be current and familiar with the State-of-the-Art.

Be as knowledgeable as possible with the current research and clinical wisdom in your areas of specialties. Belong to professional associations, attend continuing education workshops, go to conventions (local and national ones), carry out research, and read (journals, books, etc). Continue to engage in educational activities which will enhance existing skills as well as alert you to new areas of concentration.

CLOSING

These guidelines are intended as an aid to help maintain one's practice within personal and professional limits. To follow them would require continuous investments of time or money, or both--often commodities of short supply, in the overcommitted world of today's practitioner. The return on that investment, however, is immense--expanded professionalism, reduced risk of ethics complaints or malpractice claims, and a higher overall quality of service to consumers. I believe that we cannot afford NOT to make these investments in an ongoing way; Indeed, the long-term costs of not making them are substantial, and frequently not evident until one has paid dearly, in one way or another. Thank you.